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A STUDY OF BROKEN APPOINTMENTS IN  
THE PENNSYLVANIA EPSDT PROGRAM

Technical Assistance Provided  
Under Contract #SRS-500-75-0031

COMMUNITY HEALTH FOUNDATION

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# A STUDY OF BROKEN APPOINTMENTS IN THE PENNSYLVANIA EPSDT PROGRAM

## I. INTRODUCTION

### Problem Description

Broken appointments are serious deterrents to the effective and efficient delivery of health care. High rates of broken appointments contribute to low provider morale and to provider reluctance in participating in the EPSDT program. Both provider resources and the efforts of the outreach staff are wasted when appointments are not kept.

Leopold (1974) found that children from high-risk families enrolled in a Children and Youth Project, broke almost twice as many appointments as children from low-risk families. These high-risk children, who are most likely to be in need of health care, are probably disproportionately being deprived of care because of their broken appointments.

### Objectives

The objectives of the study were:

1. To identify probable causes for appointments being kept and for being broken.
2. To identify strategies for reducing no-show rates.

3. To identify ways of minimizing the impact of residual no-shows.

#### Methodology

In preparing for the study, experiences with broken appointments in several state and local EPSDT programs, as reported to Community Health Foundation, and literature on this problem were reviewed.

Ms. Rosetta Smith of Philadelphia Health Management Corporation (PHMC) and Mr. Scott Sheedy of Health Screening Research Foundation (HSRF) were interviewed to learn: (1) what their views were of the no-show problem; (2) which questions they felt should be investigated; (3) what their recommendations were for sites to visit; and (4) what statistical data related to the no-show problem were available.

The no-show problem was reviewed with James McKittrick, Welfare Program Specialist, to discuss questions to be explored and to identify potentially sensitive issues related to making site visits. It was decided to coordinate site visits in the southeastern region through Ms. Phoebe Hammond, Regional EPSDT coordinator.

The statistical data available for the counties served by the Health Screening Research Foundation (HSRF) included the estimated number of eligibles, the estimated percentage of eligibles screened, the number of appointments made each month, and the number of appointments broken each month. Data on most counties were available for the eight months of August 1975 through March 1976.

For the five counties in the southeastern region, no useful statistical data were readily available prior to the site visits.

In selecting counties to be included in the study, preference was given to counties with large numbers of eligible children and/or relatively high no-show rates. In the area served by HSRF, final selection was based on anecdotal information from Scott Sheedy and on logistical considerations.

In the southeastern region, Jean Quinn of the Southeastern Regional Office suggested appropriate providers to interview and arranged appointments.

Seven counties were selected for site visits: Allegheny, Bucks, Delaware, Erie, Fayette, Montgomery and Philadelphia.

Most of the information was gathered through the impressions of key informants. Interviews were conducted with County Welfare directors, county Board of Assistance outreach supervisors, the two Phase I contractor outreach directors, outreach workers, clerical personnel, physicians, nurses and receptionists. Local sites visited included a county health department, a Children and Youth Project, and a private physician's office. Home visits were made with outreach workers in two counties. In one county recordings of role-played outreach interviews were reviewed. Follow-up phone interviews were conducted with personnel in the counties of Fayette, Montgomery and Delaware. A phone interview was also conducted with Mr. Wilson of the Cambria County assistance office.

## II. FINDINGS FROM LITERATURE REVIEW AND OTHER EPSDT PROGRAMS

The most basic fact about broken appointments for preventive health care is that they occur more frequently than broken appointments for the care of acute illnesses. Perceived urgency is one of the most powerful factors determining the broken appointment rate and level of utilization for ambulatory services (Ambuel, et al, 1964; Andersen and Newman, 1973; Becker, 1976).

A broken appointment rate of 45 percent for well-baby visits to clinics, where no personal physician was identified, was found by Alpert (1964). The rate for endocrine, seizure and medical clinics was approximately 15 percent, and for cardiac clinic the no-show rate was about 30 percent.

A keep-rate of 46 percent for well child appointments at a health center serving a low income area was found by Nazarian, et al, 1974. ("Keep-rate" is defined by Nazarian, et al, as  $\frac{\text{appointments kept} + \text{appointments canceled}}{\text{kept} + \text{canceled} + \text{broken appointments}}$ . The "show rate" is usually defined as  $\frac{\text{number of appointments kept}}{\text{number of appointments made}}$ . The broken appointment rate is defined as  $\frac{\text{number of appointments in which the patient neither keeps the appointment nor cancels}}{\text{total number of appointments made}}$ . Note that the sum of the show rate and the broken appointment rate do not necessarily equal 100 percent because of the exclusion

of cancellations. Motil and Siar (1973) are unique in the literature in that they make a distinction between broken appointments and no-shows. They define "no-shows" as appointments which are neither kept nor cancelled, but they include cancelled appointments as well as no-shows under the category of broken appointments. In this report, the more common practice of making no distinction between broken appointments and no-shows will be followed.) The keep rate on appointments for immunization only was 56 percent, and for follow-up on acute infectious illness the rate was 63 percent.

A minimum no-show rate of about 20 percent is to be expected for general pediatric clinic visits according to Wingert, et al (1975). The baseline show rate in their general pediatric clinic was 53 percent. In specialty clinics, such as cardiology or neurology, the show rate was about 60 percent. More than half of their clinic patients were welfare recipients.

A national profile of Children and Youth Projects shows an average broken appointment rate for general medical appointments of 30 percent (Systems Development Project).

EPSDT programs usually can be expected to have higher broken appointment rates than well child programs which have more heterogeneous populations. Low income people, particularly welfare recipients, usually have lower utilization rates for preventive care and higher broken appointment rates (Kosa and Zola, 1975, Chapters 5 and 6; Leopold, 1974; Hurtado, 1973; Elling, 1960; Alpert, 1964). There is some indication that the educational level of the mother is the best single demographic

predictor of preventive health care utilization (Lefcowitz, 1973; Coburn and Pope, 1974).

Another significant factor which contributes to the higher EPSDT broken appointment rate is the personalized outreach service which is distinctive to the EPSDT program in many geographic areas. Many appointments are given by outreach workers to families which have not initiated the request for service, families which are less highly motivated and may have strong ambivalence about seeking medical services. Consequently, a higher proportion of appointments are broken than among families which initiate the request for service.

The range of the current EPSDT broken appointment experience is demonstrated by the following examples:

The State of Michigan has one of the best functioning state EPSDT programs. Michigan's program has a broken appointment rate of approximately 35 percent (Kirk, et al, 1976). Hawaii's EPSDT program also has a no-show rate of 35 percent (Hawaii Department of Health, 1975, p. 93).

Kentucky has a statewide no-show rate of roughly 50 to 60 percent. The no-show rate by county in North Carolina varies from five percent to 50 percent (Community Health Foundation Site Visits, 1976).

In urban areas, EPSDT programs tend to have higher no-show rates than they have in rural areas. For example, the no-show rate in Wayne County, Michigan (Detroit area), ranges from 50 to 60 percent. In the rural Sault Ste. Marie area, the no-show rate is around five percent (Community Health Foundation Site Visits,

1976). For the discussion of factors contributing to rural and urban differences, see pages 19-23.

#### CULTURAL VARIABLES

Part of the reason for higher broken appointments among welfare recipients for preventive health visits is related to health beliefs common among low-income sub-cultures.

Among many low income groups even serious illness is accepted as normal or inevitable. Clients may sometimes expect 'ridicule from their peers if they visit the doctor for complaints that are viewed as trivial (Koos, 1954).

Illness may be viewed as the result of individual wrongdoing or as the workings of supernatural forces. Consequently, any attempt to prevent illness through medical intervention would be viewed as nonsense.

In addition to these attitudes of stoicism and fatalism, many poor people are suspicious and hostile toward governmental representatives and physicians (Lewis, 1966).

These attitudes, combined with a low level of factual information about health matters, contribute to a general reluctance to use preventive health services, as well as many curative services.

Even when there is some interest in using health services, other factors may interfere. Poor people are frequently less accustomed to following schedules rigorously. There may be few rewards in the health setting for keeping appointments, unless a personal relationship exists with the staff (Henry, 1965; Horton,

1967). The frequent economic and social crises which the poor experience may also interfere with appointments (Lewis, 1966).

#### SERVICE VARIABLES

##### Availability of Valued Services

Three components of preventive health services are most familiar to parents and most highly valued. These components are immunization, vision care and dental care.

In Louisiana, EPSDT eligible children must be screened in order to obtain eyeglasses and dental services. The significance of these services to outreach was demonstrated when clients were unable to obtain these particular health benefits. (Funds were not available because the cost of dental services and eyeglasses had been underestimated for the fiscal year. At that time, the state constitution did not allow the budgeting of supplemental funds.) During this period, there was a dramatic increase in the no-show rate (Community Health Foundation Site Visit, 1975).

Some outreach directors and nurses feel multi-service agencies are more effective outreach agents and tend to have lower broken appointment rates than single-purpose EPSDT outreach programs. Multi-service agencies (e.g., CAP programs) do have the advantage of offering a broader range of concrete services which are more likely to be responsive to the client's felt needs. They also have the advantage of more frequent client contact and the opportunity of developing stronger relationships with clients. Multi-service agencies frequently have already

established relationships with low income populations and have favorable reputations.

#### Familiarity with Service Setting and Personnel

Clinics report lower no-show rates from clients which have had previous contact with the clinic. A public health clinic in New Orleans reported a 20 percent EPSDT no-show rate for patients previously enrolled in the clinic. Patients referred by outreach workers from the parish welfare office were estimated to have a no-show rate of about 80 percent.

Other clinics report that broken appointments decrease in frequency with successive children as the mother acquires more experience in the health care setting.

Outreach workers for the Kaiser Foundation Health Plan in Hawaii feel they can categorize AFDC mothers as independent or dependent after two or three months contact. (Dependent is defined as requiring special support in keeping appointments or utilizing services.) About five percent of their families are classified initially as dependent. Most become independent over time as the outreach workers educate them in the use of the health care system.

#### Client Attitudes to Welfare Workers

Placek (1975) maintains that welfare workers may have difficulty in serving as outreach workers because of the social distance between clients and workers. Clients frequently distrust welfare workers simply because they work for the welfare department (Blau, 1960). In other instances, distrust grows out of

social or racial differences.

A study by Freidson (1959, as cited by Placek, 1975) indicates that clients view social workers as distant from health affairs.

Kadushin (1972) after reviewing the literature on the impact of racial differences between clients and workers, concludes that these barriers can be overcome with proper training and cultural sensitivity. However, when possible, social distance between clients and workers should be minimized.

#### Waiting Period

Moore and Stewart (1972) list the length of time between scheduling and the time of the clinic visit as a factor influencing the productivity of outreach workers.

Salinas (1972) found that when the waiting interval was longer than two weeks, the broken appointment rate was higher.

### ADDITIONAL SOCIO-DEMOGRAPHIC VARIABLES

#### Family Structure

Adler (1963) found that divorced and separated patients broke more psychiatric appointments than patients from intact families. In studies of pediatric broken appointments, Alpert (1964) and Leopold (1974) found that families with more children tended to have higher broken appointment rates.

Extended families tend to be lower risk families and to have lower broken appointment rates, perhaps in part because of the availability of other family members to care for children

who are not being screened (Leopold, 1974). Extended families may also have lower levels of social isolation and social disorganization and more resources for dealing with family crises.

Family disharmony (Elling, 1960) and unsatisfactory marriage (Stine, 1968) have also been found to be predictive of higher rates of broken appointments.

### Age

The evidence on the effect of age on broken appointments is contradictory. Most studies (e.g., Badgely, 1961; Salinas, 1972; Shonick and Klein, 1975) indicate that mothers with young children have higher broken appointment rates. However, Motil and Siar (1973) found no significant difference in the broken appointment rates for children between the ages of birth to 4, 4 to 8, and 8 to 12. Field interviews (Community Health Foundation) suggest that the critical factor may be the number of preschool children in the family.

An age-related factor is immunization status. Hansen (1953) found that children whose immunizations were completed had a higher broken appointment rate than children whose immunizations were incomplete. This finding is related to the fact that many parents feel that immunization is the major reason for seeking well-child care.

### Ethnicity

Many studies (Alpert, 1964; Elling, 1965; Jonas, 1971) find that non-white ethnic status is associated with higher broken appointment rates. However, other studies (Shonick and

Klein, 1975; Badgely, 1961; Lefcowitz, 1973) indicate that income and education are better predictors of preventive health behavior.

Shonick and Klein found that when income is controlled, there are no ethnic differences in broken appointment rates. Badgely found that low income whites also have high broken appointment rates.

### III. DEMONSTRATED APPROACHES TO REDUCING BROKEN APPOINTMENTS

#### Appointment Reminders

The keep-rate for well child appointments was improved by 16 percent from 46 percent to 62 percent ( $p < 0.001$ ) by mailing appointment reminders (Nazarian, et al, 1974). The post card reminders were mailed one week prior to the appointment.

The interval from the time the appointment was made to the time of the appointment varied from 12 days to eight weeks. The reminder produced the greatest improvement in keep-rate (from 33 percent to 55 percent) for the interval of 29 through 35 days. However, the data on the effect of the length of interval to appointment was not analyzed separately for well child visits and acute visits. (The analysis of the data might also have been improved by computing moving averages.)

Hansen (1953) and Schroeder (1973) also found post card reminders to be effective in reducing broken appointment rates. Schroeder found post cards to be somewhat more effective than phone calls in reducing the broken appointment rate. Post card reminders reduced the broken appointment rate from 24.6 percent to 13.7 percent.

#### Continuity of Care and Personalized Services

In a survey of private physicians and clinics to determine the broken appointment rates and cancellation rates, Alpert

(1964) found a significantly higher broken appointment rate in those clinics which made no attempt to have a patient followed by the same physician. The average broken appointment rate for clinics which did not provide continuity of physician care was 22.7 percent. The average broken appointment rate for clinics which provided continuity of care was 7.5 percent. The cancellation rate for clinics which did not provide personalized physician care was 7.8 percent. The personalized care clinics had a cancellation rate of 14.5 percent. The low broken appointment rate and high cancellation rate of the clinics which provided personalized care was almost identical to that of private pediatricians' offices. There are three major limitations of the Alpert study: (1) The Alpert study includes settings which provide both preventive and curative care and the data on the two types of care are not well separated. (2) The socio-economic mix of the clients in the various practice settings are not specified. (3) The analysis is based on correlational data, consequently, the inference of causality has a weak basis, even though Alpert presents a convincing argument which has face validity for application to EPSDT.

Two other impressive studies complement Alpert's study and confirm the validity of his findings.

Motil and Siar (1973) demonstrate a reduction in the no-show rate from 48.0 percent to 13.8 percent for a general pediatric outpatient clinic. The rate of cancelled appointments was increased from 3.3 percent to 10.8 percent. The rate of non-urgent emergency room visits was reduced 95.2 percent.

The reduction was achieved by changing from block appointments to individual appointments, providing for continuity of physician care, strictly enforcing a cancellation policy, using nurse practitioners for well-baby care and providing 24 hour access to a physician by telephone.

The study provides separate data on welfare recipients. There was a reduction in the broken appointment rate for all patients from 51.3 percent to 24.6 percent. (Note that Motil and Siar include cancelled appointments as broken appointments but not as no-shows.) The reduction in the broken appointment rate for patients on welfare was from 53.4 percent to 27.6 percent.

Continuity of care and personalized service through the employment of indigenous health aides in an outpatient pediatric department was introduced by Wingert, et al (1975). The aides not only provided screening services as a part of systematic child health supervision, they also engaged in "patient pursuit." They sought out patients for follow-up, made appointments when necessary, provided transportation, and accompanied the patients to clinics and social agencies. The introduction of the aides as health coordinators improved the compliance rate for appointments from 53 percent to a rate of 80 to 90 percent. After implementing a similar program at Yale, Beloff and Korper (1972) report a decrease in the no-show rate from 15-30 percent to 2-7 percent. ✓

Reduction of patient waiting time through the use of individual appointments may lead to a reduction in the broken

appointment rate independently of other aspects of personalization of care (Rockart and Hoffman, 1969). However, the most significant factor in personalization of care seems to be the quality of client-staff relationships. Elling (1960) concluded that low socio-economic status affected broken appointments primarily because of its impact on the mother's reflexive self-concept, that is, the mother's perception of how she is evaluated by the physician.

The importance of warmth and rapport between physician and patient in determining patient compliance has been supported by numerous studies. (Davis, 1968; Korsch, et al, 1969; Korsch and Negrete, 1972). Glogow (1970) found a comparable reduction in broken appointments associated with increased personalized attention from nurses.

#### Transportation

In EPSDT programs across the country, the lowest broken appointment rates (5-30 percent) tend to be in rural counties where aggressive outreach services are provided, including the direct provision of transportation by the outreach worker. (The effect seems to be accentuated where there are providers with an established reputation for providing good well child services to low income families, and where the stigma of receiving welfare services is minimal.)

A brief demonstration project in Harris County (Houston) Texas (Texas Department of Public Welfare, 1975) increased the show rate from 53 percent to over 60 percent by providing cash reimbursement at the screening site for transportation expenses

assumed to be incurred by the client. Clients were reimbursed \$2.00 per child screened.

Unfortunately, a public bus strike coincided with the demonstration period. The public buses are a major source of transportation for Houston's AFDC clients. Consequently, a considerably larger increase in the show rate might have been expected under usual conditions.

A similar approach to providing reimbursement for transportation related to welfare medical care was reported by Goodrich, et al (1970). However, they report only the impression that on-site cash reimbursement was helpful in ensuring access and encouraging utilization.

In another phase of the Harris County project, transportation was provided by radio-dispatched vans which were under contract. This approach resulted in an increase in the show rate from 50 percent to over 70 percent.

The direct cost of providing transportation by van was approximately \$4.00 per screen, or twice the cost of the direct reimbursement approach. In addition, providing transportation by van made scheduling more complicated, and required that outreach workers spend a great deal more time in their client contacts.

Nurses in North Dakota (Community Health Foundation site visit, 1975) report that the broken appointment rate increases at the end of the month just before welfare checks are received. Some clients do not have enough money to buy gas at the end of the month, and consequently, break their appointments.

#### IV. FINDINGS FROM SITE VISITS

Site visits were made to seven counties in Pennsylvania. These counties involved both rural and urban areas, thus offering an opportunity to study various types of facilities and personnel. Data related to the impact of specific factors effecting no-show rates were difficult to obtain.

The impressions and opinions of informants within the same county were sometimes contradictory. For example, in one county, estimates of the proportion of clients who refused a second appointment after breaking an appointment varied from 10 percent to 40 percent.

Definitions of what was counted as a no-show or broken appointment varied from county to county. Various counties included categories, such as cancellations by providers, refusals by providers to see late clients, clients who left the screening site before being seen and clients who cancelled on the day of the appointment. Because of the lack of uniform reporting practices, interpretations of broken appointment data must be made with caution.

Two counties were identified which do not remind clients of their appointments. In one county, the explanation was given that the outreach workers "don't have time." It was suggested that the payoff in number of additional children screened would probably be greater for each unit of time invested in reminders

rather than in scheduling new appointments.

In two counties, there was no special emphasis to the client on the importance of cancelling appointments which could not be kept. This practice was recommended.

Four counties were mailing appointments to clients. It was recommended that appointments be made in the home, if possible, or by telephone. (This is easily accomplished if each worker is given, in advance, distinct blocks of appointments to fill.)

In a number of counties, it was reported that outreach workers were focusing upon the number of appointments which they made rather than upon the number of children screened as a result of their effort. They were trying to meet an appointment quota rather than a screening quota. Consequently, they were repeatedly rescheduling clients who had already broken several appointments and apparently were not interested in having their children screened. It also seems that reluctant and resistant clients may be scheduled without ensuring that they understand the program and really want their children screened.

One county EPSDT coordinator felt that the broken appointment rate had increased since the implementation of the quota system because workers are attempting to contact more clients, but are making fewer personal contacts.

Data from other states support the finding that the lowest broken appointment rates are found in rural areas. This finding is illustrated by the show rates for a representative month in Erie County in Table 1. The show rate within the city of Erie

was 48 percent. The show rate in the area outside the city of Erie was 87 percent.

Table 1: Show Rates by Provider Site Location for a Representative Month in Erie County

<u>Urban</u>		
<u>Provider Site</u>	<u>Show Rate</u>	
Health Center A	( 50/91 )	55%
Health Center B	( 51/108 )	47%
Health Center C	( 47/107 )	44%
Total	(148/306)	48%
<u>Rural</u>		
<u>Provider Site</u>	<u>Show Rate</u>	
Private Physician A	( 18/21 )	86%
Private Physician B	( 20/24 )	83%
Private Physician C	( 18/21 )	86%
Family Planning Clinic	( 34/37 )	92%
Total	( 90/103 )	87%
County Total	(238/409)	58%

This difference is particularly interesting because it is an intra-county difference rather than the more frequently noted difference between rural counties and urban counties. Consequently, the outreach and scheduling procedures are relatively uniform, and are unlikely to contribute much to the difference in show rates. Although differences in the personal effectiveness of outreach workers might theoretically account for much of the variance, such a systematic bias is unlikely and was discounted by local staff.

The most probable explanation is that the difference in show rates is due to socio-cultural differences in the mix<sup>o</sup> of

clients. In the urban area, welfare clients tend to have a longer history of dependency, to be more socially disorganized, to have fewer social links in the neighborhood and to have lower self-esteem. (See Katz, et al, 1975, pp. 9-13, on the effects of dependency on self-esteem.) Outreach workers report that "hard-core" families have a higher broken appointment rate. One worker said, "We have better success with the ones who have just gotten on."

This finding is supported by the literature which indicates that socially isolated, poorly educated and socially disorganized families use child health services less effectively than more socially integrated families. (Shindell, et al, 1976; Lefcowitz, 1973; Suchman, 1965; Leopold, 1974; Salloway and Drion, 1974; Bowles, 1969.)

Several other factors may contribute to the difference in broken appointment rates between urban and rural areas. The "culture of poverty" (Lewis, 1966) characterized by hostility to bureaucracies, apathy, fatalism and suspicion is less pervasive in rural areas than in inner city areas.

Access to medical care is taken for granted less in rural areas than in urban areas. Several outreach workers in rural areas reported that their clients experience difficulty in getting appointments for medical care and appreciate assistance from the worker in making appointments.

There is some indication that clients living near hospitals and clinics in urban areas break more appointments. Lane (1974) found that "walk-ins" (clients who appeared for service without

appointments) tended to live closer to the clinic and to have a record of more consecutive broken appointments than a comparison group of clients who were not "walk-ins." Alpert (1964) identified a similar population near the hospital with a high broken appointment rate. However, hospitals and clinics often tend to be located in neighborhoods with high concentrations of socially disorganized, isolated clients. Consequently, the effect of distance may be compounded with the effect of socio-cultural factors.

In rural areas, there seems to be less social distance between welfare workers and their clients. Rural clients are probably more open to unannounced strangers knocking on their door.

One might speculate that the higher urban no-show rate is accounted for, in part, by the broader range of available social activities in cities which compete with preventive visits as a way for mothers and children to structure their time. Going to the doctor may be a more attractive social opportunity for rural families. (This proto-hypothesis could only be confirmed or disconfirmed through time-budget analysis or through intensive ethnographic study.)

Rural areas with the lowest no-show rates tend to be counties characterized by "aggressive outreach" approaches. (See Attachment.) These counties tend to supply transportation directly. Their outreach workers help wash and dress children who are not ready. These counties tend to have specialized EPSDT units which have no other responsibilities.

In some rural areas, there may be more favorable staff/

client ratios. However, this was not a relevant factor in Erie County.

In summary, the difference in broken appointment rates between the urban and rural sections of Erie County are most probably a function of the differences in the mix of clients. The urban clients are likely to have a longer history of dependency, to be more socially disorganized, to be more socially isolated, to have lower self-esteem and are more likely to be Black.

There seem to be interaction effects between weather, type of client mix and location (urban-rural).

The outreach staff in Erie County reported that the no-show rate in the area outside the city increases substantially during periods of severe winter weather. Other counties report similar experiences in rural areas. In contrast, the Kent County, Michigan, EPSDT program finds that the no-show rate increases predictably in the "inner-city" area during especially good weather. No similar increase is found among the more socially integrated families with a shorter history of dependency who tend to live outside the "inner-city." (Personal communication with Frances Snyder.)

Differences in the level of social integration may account for some differences in the broken appointment rates of communities at about the same point on the urban-rural continuum. In Bucks County, several welfare workers agreed this was an important factor in the difference in broken appointment rates in Levittown and Warminster Heights. Warminster Heights was described as "a real community" and as a community with a remarkably low broken appointment

rate. Levittown was said to have "little sense of community" and to have a relatively high rate of broken appointments. (No community-specific quantitative data were readily available.) Levittown is viewed as a difficult community in which to do "door-to-door" outreach.

Warminster Heights has a community health center which is closely identified with the community and enjoys an excellent reputation. The center has its own outreach worker who takes health histories in the home.

Some clients are reluctant to use EPSDT services because of the stigma attached to welfare status in the community, provider attitudes to welfare clients and/or their own feelings about independence and dependency. These attitudes vary widely by ethnic group and geographic area.

Reluctance to use EPSDT was sometimes expressed by clients in comments such as, "Somebody else might need it more." (Related attitudes are indicated by the refusal of families which are financially eligible to apply for welfare benefits, or sometimes even social security benefits.) This reluctance was especially noted in Montgomery County and Fayette County. This attitude seems to be especially prevalent among clients of Eastern European descent. (See Lindstrom, 1975, p. 758, for an example of a similar attitude among Chicanos.) If the outreach worker attempts to persuade the client to accept appointments without attempting to understand the feelings associated with the client's reluctance, broken appointments are likely to result.

Evidence of general hostility to welfare clients was found

in Montgomery County and Fayette County. One instance was reported of a nurse who decided which EPSDT eligibles were "worthy" of receiving screening services.

In Fayette County, the local paper publishes editorials hostile to welfare recipients, referring to them as "reliefers." Some physicians were reported to have had signs in their offices which read, "No Reliefers Treated." Other physicians' offices turn patients away after their eligibility is discovered. One reported dialogue follows:

Receptionist: "How are you going to pay for this?"

Client: "I'm on relief."

Receptionist: "Doctor isn't taking any more new patients."

This general antipathy to welfare clients discourages them from seeking medical care in non-emergency situations. Provider-client relations are further disrupted by EPSDT providers who refuse to see clients with appointments, telling them to return on another day.

In addition, many physicians discourage patients from calling on them for minor ailments. Their message is, "Don't come to see me unless you're really sick." This reinforces the belief common among lower class groups that there is no reason to see a doctor unless one is ill.

These sources of reluctance and resistance may easily overcome already weak motivation for preventive health care visits. Even if the client does reluctantly accept an appointment for EPSDT services, the negative components of ambivalence are easily triggered by weak motivational forces resulting in many broken

appointments.

The personality of the outreach worker was mentioned by several county EPSDT coordinators and outreach supervisors as the factor accounting for most of the variation in no-show rates from worker to worker. (In Allegheny County, the no-show rate by outreach worker varies from 10 percent to 50 percent.) The most effective workers were described as "bright, motivated, more enthusiastic, extroverted and concerned." In one county, it could be predicted which workers would have the highest and lowest no-show rates on the basis of brief conversations with the outreach workers. (The importance of eye contact and non-verbal cues, such as smiles, in personal persuasion is well documented. See Argyle, 1972.) The style of presentation is probably also a significant factor. In listening to recordings of role-played outreach interviews, observing actual outreach interviews, and talking with outreach workers, it was noted that outreach workers sometimes engaged in long monologues. Clients were not actively encouraged to respond by providing pauses or asking questions. Outreach interviews often had a "canned presentation" quality rather than a conversational style. Sometimes the components of the screening package were recited in one long list using technical terms and giving no explanation of the significance of the various components. There was no concrete discussion of the specific health needs of the children in the family.

The varying estimates given of the number of clients who refuse a second appointment after breaking one appointment are: 10 percent, 25 percent, 30 percent and 40 percent. The number

who refuse a second appointment is probably a low estimate of the number of clients who accept appointments with little or no intention of keeping the appointment. The classical response from this type of client is, "I thought it over and I don't think it's necessary."

Others decline on the basis that they don't have transportation or child care for other children. The validity of this response must be evaluated in relation to whether the county has actually made supportive services readily available and whether the client feels comfortable in accepting the supportive services. In some instances, the client may simply be reluctant to flatly refuse the screening services.

The actual number of clients who refuse a second appointment may be a valuable management indicator. A high number of refusals may indicate that outreach workers are overselling.

None of the counties visited had summary statistics on the number of clients who refused second appointments, and some were reluctant to make an estimate.

In two counties, outreach workers reported difficulty in getting requests for transportation reimbursement processed. In some instances, reimbursement was lost because requests were not processed within the prescribed time limits. These organizational barriers detract from the credibility of the program and may be a contributory factor in broken appointments as well as refusals of service.

In these counties, it was recommended that: (a) outreach workers be delegated authority to authorize reimbursement; (b) if

considerations of territoriality and union pressure make this possibility inexpedient, outreach workers be directed to fill out the reimbursement form (FC43) and submit it to the case worker for approval.

In some counties, one or two additional trips to the welfare office may be required of the client to receive reimbursement for transportation related to EPSDT. The welfare office is often unable to mail out carfare or bus tokens in time for clients to keep their appointments.

In Allegheny County, it is estimated that approximately 30 percent of the clients screened use transportation provided by HSRF. A substantial but unquantified proportion of clients request transportation services, but decline when the van arrives, or are not even at home. In some instances, the child may be away, although the parent is home. Or the parent may report, "He decided he didn't want to go."

In Allegheny County, it is estimated that of the persons contacted by HSRF outreach workers, 10-15 percent refuse service initially, 40-45 percent accept appointments, and 38-45 percent are ineligible. (The high number of ineligibles is due to the difficulty in getting accurate, up-to-date eligibility information from the Allegheny County Welfare Office. The difficulty has been compounded by the Welfare Office's reluctance to provide telephone numbers for EPSDT eligibles.)

For the months of February, March and April, Allegheny County had a show rate of 66 percent. About 5 percent of the clients scheduled cancel prior to the time of the appointment.

Estimates of the percentage of clients who refused a second appointment vary between 10 percent and 30-40 percent. This would indicate that a minimum of 3.4 percent to 12 percent of those originally scheduled had little or no intention of keeping the appointment. Of those who were rescheduled for screening, approximately 35-40 percent kept their appointments. (Some clients were rescheduled more than once, sometimes as often as four or five times. Consequently, the show rate for second appointments can be inferred to be slightly higher than 40 percent.)

The number of clients who kept rescheduled appointments can be taken as a rough estimate of the number of clients who intended to keep the first appointment, but for some reason did not. If the actual count were known of those who refused second appointments and those who were not contacted for rescheduling, a more precise estimate could be made.

In two counties, it was reported that clients have difficulty in reaching doctors' offices or welfare offices because the lines are busy. Consequently, clients are discouraged from calling to cancel appointments.

Both providers and welfare workers have observed lower no-show rates when clients make their own appointments directly with the provider. Several providers insist that clients make their own appointments. Some providers have found that they can also reduce repeated broken appointments by following up on broken appointments and rescheduling them directly. Some clinics also make telephone calls to remind clients of their appointments, and have found this to be helpful in reducing broken appointments.

Based on their personal impressions, some outreach workers mentioned the lag between the time when an appointment is given and the time for which screening is scheduled as a factor in broken appointments. Those who mentioned this factor felt that the lag time should be no more than ten to fourteen days. One county, which routinely mails appointments, schedules as much as one month in advance for a popular doctor. However, the appointments are not mailed until one week prior to the time scheduled for screening.

Other counties, which sometimes scheduled three to four weeks in advance, did not mention lag time as a factor. In some instances, the potential effect of lag time may be moderated by reminders and/or unusually good relations between clients, providers and outreach staff.

Some welfare staff mentioned distance to the screening site as a contributing factor in broken appointments. Others mentioned the unavailability of transportation with little sense of the welfare department's responsibility to assure that transportation is provided.

A county health department which was visited reported that they reduced their EPSDT no-show rate from 50 percent to 20 percent by stopping the practice of repeatedly rescheduling broken appointments. The welfare department's outreach workers make the initial appointment, and the health department performs all outreach functions after the family is enrolled at the clinic during the initial visit. The clinic now reschedules only once after a broken appointment. This practice has been in effect for six

months and the no-show rate has remained stable at 20 percent.

In Delaware County, the outreach workers put more emphasis on scheduling new appointments than on rescheduling broken appointments. The clinics and some solo practitioners do their own rescheduling. Two clinics also call the day prior to the day of the appointment to remind the family.

Less than one-half of the clients who fail to keep their appointments call to cancel or change their appointments. People who call after breaking an appointment usually keep the second appointment. The clinics reschedule about one-half of the broken appointments.

It was reported in Delaware County that mothers with only one or two children are more likely to keep their appointments than mothers with larger families. This phenomenon was also noted in Philadelphia. In Philadelphia, the availability of escort service is mentioned to all families, but it is emphasized to families with three or more children.

The nurse at the Children and Youth Project, which was visited, reported that children who have had no previous contact with the health center have higher broken appointment rates than children who have had previous contact with the center. Young mothers who were enrolled in the Children and Youth program not only have a better show rate, but also frequently bring in their younger brothers and sisters to be screened. (Grandmothers also frequently bring in their grandchildren to be screened.)

The center has an EPSDT broken appointment rate of about fifty percent. The broken appointment rate for Children and Youth

enrollees is estimated to be between 30 and 40 percent. The rate for Children and Youth enrollees was improved by stopping mailing appointments. Instead, reminders were mailed to parents asking them to call for an appointment.

It is reported that camp physicals and work physicals (for older teenagers) frequently bring in children who have previously broken appointments.

The center refuses to schedule more than two children from a family for the same visit unless the family promises to keep the appointment or to call and cancel it.

ADDITIONAL REASONS GIVEN FOR  
APPOINTMENTS BEING BROKEN

The following tables list reasons given for missing appointments. Table 2 lists reasons given by clients to health workers and welfare workers. Table 3 lists concerns expressed by clients which are related to ambivalences and resistances which contribute to broken appointments. Table 4 lists psychological reasons which welfare workers believe are significant factors contributing to broken appointments, although they are rarely expressed directly by clients. Table 5 lists similar psychological reasons reported by health workers. The reasons for missing appointments given most frequently by clients are related to transportation problems, illness, family crises, and failure to remember. These findings are comparable to those of other studies. (See Walsh, et al, 1967; and Motil and Siar, 1973.)

Table 2: Reasons Given by Clients for Missing Appointments (As Reported by Health and Welfare Workers)

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The car broke down.  
I forgot.  
I thought it over and I don't think it's necessary.  
I was sick.  
The kids were sick.  
Something happened at home.  
I thought somebody else might need it more.  
I forgot to get up.  
The children decided they didn't want to go.  
I didn't want to take the kids out of school.  
I was too busy.  
I had something else to do.  
I forgot and sent my child to school.

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Table 3: Concerns Expressed by Clients Relevant to Broken Appointments  
(As Reported by Welfare Workers)

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How long will I have to wait?  
 Will he be my family doctor?  
 What do I have to sign? I want to sign and get out. (Comment  
 by client being informed about EPSDT after spending most  
 of the day in the welfare office for intake.)

---

The reasons given by clients are difficult to validate without personal access to their social networks. (See Bernal, et al, 1974; and Sheehan, 1976.) Welfare workers differ widely in their estimates of the validity of the reasons given by their clients. Some feel that most reasons given are valid. Others feel that most reasons given are invalid.

In the rural areas, welfare workers estimate that seventy to ninety percent of the clients have access to cars. However, many of the cars are notoriously unreliable. Also, the automobile often belongs to a friend or relative, and the mother is dependent both on the physical presence and good will of the owner.

Automobiles are frequently unavailable during the day because they are used for travel to and from work. There is some feeling that there are fewer broken appointments between 6:30 and 8:30 p.m., because cars are more available then. It was also noted that during football season, Monday evening is a poor time to schedule EPSDT appointments. (Personal communication from Scott Sheedy.)

Leopold (1974) found that the highest rate of broken appointments tends to occur among socially disorganized,

multi-problem families with low health status. Consequently, it should not be surprising to find frequent illnesses and family crises which interfere with screening appointments.

The frequency with which clients fail to remember appointments is related to several factors. There is low motivation to remember because:

1. Preventive health care is of low salience to many welfare recipients.
2. Many recipients are suspicious, frightened, and/or hostile in relation to physicians, health care institutions and welfare workers.
3. The concept of preventive care is contrary to the assumptive world of some low-income sub-cultures.
4. There is little social support for role behaviors oriented toward preventive health care.

In addition, the lives of many poor people are little regulated by abstract calendar dates and times. Health care appointments are not usually part of a regular round of familiar activities. (See Henry, 1965; Horton, 1967; Strauss, 1969.)

The comments by welfare and health workers on why clients break appointments are instructive.

Table 4: Reasons Given by Welfare Workers for Broken Appointments

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- "They (clients) make the appointment to satisfy you."
  - "If a worker from our office tells them something they feel they have to agree to it."
  - "Some physicians are 'smug and arrogant.'"
  - "Some (clients) are afraid of losing their check."
  - "Something might happen to their checks."
  - "Some (clients) don't want to wait a half hour for a doctor."
  - "I feel there's a built-in apathy with these people -- otherwise they wouldn't be on welfare."
  - "Sometimes they go to the (screening) site and don't even know why they are there."
  - "Other issues are of higher priority. It's just not important to them."
- 

Table 5: Reasons Given by Health Workers for Broken Appointments

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- "If these people aren't sick, they just don't think about going to a doctor." (Comment by indigenous community health aide.) (See similar comments in Lindstrom, 1975, p. 758.)
  - "A lot of people who come in here feel that this is directly related to receiving their check." (Comment by a public health nurse.)
  - "If the parent didn't have to be involved, they would send the child. Many parents prefer to have children examined in school because they don't have to be involved."
  - "Seemingly there is a group that is only oriented to acute problems. If there is no problem, they can't be bothered."
  - "They don't state it, but sometimes it interferes with their soap operas." (Comments by a nurse in a neighborhood based clinic.)
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Almost universally the impression is of substantial numbers of clients acquiescing to screening appointments at the urging of outreach workers, without conviction in its importance or understanding its purpose.

Clients accept appointments because they wish to please the worker or because they fear sanctions which might lead to the loss of the custody of their children (a rare fear) or to the stoppage of their welfare checks (a common fear). They may accept

appointments despite negative feelings about the prospects of travel with their children, and lengthy waits at the screening site, and despite negative feelings about health care providers. Consequently, the motivation to keep appointments is often weak and is easily neutralized by ambivalences and resistances.

## V. RECOMMENDATIONS

Possible ways of reducing broken appointment rates have been considered for the following aspects of the EPSDT program: outreach approaches, outreach management, transportation, provider approaches and programmatic approaches.

### Outreach Approaches

1. Ensure that outreach workers or provider staff remind clients of appointments.

2. Discourage the practice of making appointments by mail. Outreach workers should talk personally with clients to ensure that the appointment time and place is convenient. This may be facilitated by assigning each outreach worker distinct blocks of appointments to fill. This allows appointments to be made at initial contact.

3. Avoid long monologues in outreach interviews. Clients should be encouraged to respond immediately to questions and comments. Questions which might be asked include: "Have you heard of the early screening program for children? Where do you take your children for health care? Have you arranged for a screening examination? What assistance do you need in receiving these services?"

Unless there are pauses and chances to respond, the client may feel that he is listening to a tape-recorded message and will

respond negatively. A more conversational style helps to establish better rapport with the clients and will also help the worker find out more about the clients' attitudes toward health care, and potential barriers and resistances to using EPSDT services. For example, the outreach worker may want to find out what transportation the mother normally uses for obtaining medical care or for grocery shopping. Does she often have to "con" or cajole a neighbor or relative into providing a ride?

Repeating a memorized list of screening items is less likely to be helpful than discussing the needs of the parent's own children. It may be helpful to ask questions such as, "Have all of the children had their shots?" "Do you know which shots they have had?" "Have they had their eyes and ears checked?"

4. Avoid using technical language which may not be understood. For example, the term "shots" is more likely to be understood than the term "immunizations."

5. Try not to overcome clients' objections until the objection has been restated by the outreach worker. Restatement is a way of: (a) ensuring that the objection is accurately understood; (b) letting client know that the objection is understood; (c) reducing defensiveness.

6. Avoid high pressure approaches and "lesser decision" closing techniques. (In the "lesser decision" closing technique, instead of asking, "Would you like to have your children screened?" the worker asks, "Which would you rather see, Dr. Smith or Dr. Jones?" Or the worker may ask, "Would you rather go in the morning or in the afternoon?")

The "lesser decision" technique will generate more appointments, but will also increase the broken appointment rate.

The number of clients who refuse a second appointment after breaking the first appointment can be used as one index of whether outreach workers are "overselling."

7. Provide training for outreach workers in active listening, Human Effectiveness Training or similar communications skills. (See Gordon, 1970; Ivey, 1971; Jongeward, 1976; McGill, 1975; Overberger, 1976).

8. Stress the importance of clients calling if the appointment is not convenient, or if, for any reason, they decide not to keep the appointment. Clients may be instructed to call either the EPSDT unit or the screening provider. Instructions about where to call should be included on appointment slips.

9. Encouraging clients to cancel or reschedule appointments is pointless unless phone lines to the EPSDT unit or providers are readily accessible. The availability of open lines should be ensured. Welfare offices with overloaded switchboards should consider installing direct lines to the EPSDT units.

10. Follow-up calls on broken appointments should be "low-keyed," warm, friendly and non-threatening in the initial approach. After giving the client an opportunity to offer any explanation of the reason for breaking the appointment, the worker should emphasize that: (a) accepting screening services is voluntary; (b) assistance in receiving service is available, if desired. Clients should not be pressured into accepting second appointments.

11. Broken appointment rates can be reduced by requiring families which repeatedly break appointments to take the initiative in rescheduling. For example, if a family breaks two successive appointments, a letter might be sent to the family informing them that if they wish to have another appointment they must contact either the provider or the outreach worker (as appropriate).

12. Broken appointments for adolescents can be reduced by involving the children in the decisions of whether to be screened, where and when.

13. No-show rates may be reduced by encouraging clients to make their own appointments. However, it is probable that the outreach yield/1000 contacts will also be reduced.

#### Outreach Management

1. The primary outreach emphasis should be on the number of screens completed, rather than on the number of appointments made. If the primary focus is on the number of appointments made, incentives are created for outreach workers to encourage verbal consent rather than behavioral compliance.

2. Each county EPSDT unit should monitor the broken appointment rate of each outreach worker. It may also be desirable to periodically compare the rates of different providers.

3. It may be helpful to display to the staff a chart of the broken appointment rates of each outreach worker, along with other measures of productivity, such as number of contacts, number of appointments and number of screens completed.

Transportation

1. Offer to help arrange transportation, if necessary.
2. Find out if the client has a way to get to the screening site. See if the client has specific plans for transportation. If not, it may be desirable to reassess the client's motivation and to re-emphasize that the program is voluntary.

3. In areas where transportation is a problem, it may be desirable to reimburse agencies, such as Head Start, Community Action Agencies and Senior Citizen groups to provide transportation on a mileage basis.

4. Procedures for transportation reimbursement should be simplified. Among the possible approaches are: (a) outreach workers could be delegated authority to authorize reimbursement; (b) if considerations of territoriality and union pressure make this possibility inexpedient, outreach workers might be directed to fill out the reimbursement form (FC43) and submit it to the case worker for approval; (c) ideally, providers might be authorized to reimburse clients for transportation on-site.

The third option might be applied only to screening visits, or might also be applied to diagnosis and treatment visits. If a flat reimbursement rate per visit were established, processing costs could be reduced. (Provisions should be made for special rates for families with unusual transportation requirements, e.g., physically handicapped parents or families which must travel long distances.)

If the routine reimbursement rate were set slightly higher than the average cost of transportation per visit, a legitimate concrete incentive would be established for utilizing preventive

health services. This approach might reasonably be expected to produce a marked reduction in broken appointment rates. In urban areas with accessible public transportation systems, this approach is probably one of the most promising cost effective strategies for increasing outreach yield.

#### Provider Approaches

1. Health personnel or personnel identified with a health setting may be more influential in diminishing broken appointments. It may be desirable to have providers make their own appointments and to reschedule their own appointments after the initial contact.

2. Providers should be encouraged to inform parents of the next time when their children should be seen and to give a reason for the appointment. This should increase receptivity to appointments for rescreening and reduce subsequent broken appointments.

If desired, a slip can be given to the parents suggesting a tentative appointment time and asking the parents to call to confirm the appointment. However, the response rate is not likely to be great and most parents will require a call from the provider or outreach worker to initiate the appointment for rescreening.

Another approach is to mail reminders asking the parent to call for an appointment, giving appointments only to those parents who call and request one. This approach will minimize broken appointments, but will usually diminish the total screening volume.

3. Continuity of care and continuity of relationships

should be encouraged for both the staff of screening providers and outreach staff. Each outreach worker should have sole responsibility for a geographic area and turnover should be minimized. Institutional providers should identify one individual to serve as the coordinator of care and communication link for each family.

4. Providers should be discouraged from using block scheduling. Block scheduling tends to be associated with long patient waiting times, higher broken appointment rates, and patient dissatisfaction. However, they may overschedule more heavily during the early morning or late evening hours if the no-show rate tends to be higher during those times. If providers insist on block scheduling, reducing the periods to blocks of one hour or less will reduce patient waiting time substantially, improve patient morale, improve utilization and reduce broken appointments.

5. Special times and settings for ethnic and cultural minorities unfamiliar and uncomfortable with the established delivery system may be helpful. It may also be desirable in some instances to establish special times and settings for screening adolescents who may be reluctant to be screened in settings with younger children.

#### Programmatic Approaches

1. Multi-service outreach agencies seem to have a lower broken appointment rate than single purpose EPSDT agencies, although they may also make fewer appointments per 100 contacts.

Multi-service agencies tend to have higher credibility because they offer concrete services valued by clients and focus on the felt needs of clients. They also tend to have established relationships with a large number of clients. (Sunley, 1968.)

Agencies which have established relationships with special populations (ethnic groups or low-income neighborhoods) should be encouraged to refer EPSDT eligibles for screening. These agencies include ethnic social service agencies, child welfare agencies, CAP agencies, settlement houses, neighborhood centers and Head Start programs.

2. Some programs have eliminated the no-show problem by screening in the home. (Frankenburg and Cohrs, 1973; Dawson, et al, 1975) This approach is especially appropriate in sparsely populated rural areas. However, it has been used successfully in housing projects. If the no-show rate is high, in areas such as housing projects, parents might be offered the choice between screening in the home and an office appointment.

3. Screening in the school will practically eliminate the problem of broken appointments and will dramatically decrease outreach cost per child screened. Where the quality of screening and adequacy of follow-up can be assured, screening in the school should be strongly considered as the screening strategy of choice. This strategy is most practical in schools with a large proportion of EPSDT eligibles.

4. The Department of Public Welfare should consider contracting with community agencies and/or health providers to provide outreach services. Cost effectiveness could best be optimized by reimbursing on the basis of the number of children

actually screened, rather than on the basis of the number of families contacted or the number of person-hours expended.

Ideally, the outreach and case management functions should be performed by personnel identified with a comprehensive health care setting. The same organization should have the capability to reimburse clients directly for transportation, to provide transportation, or to authorize transportation. Internal quality controls should be required with guaranteed access for external program monitoring.

## VI. WAYS OF MINIMIZING THE IMPACT OF RESIDUAL BROKEN APPOINTMENTS

Even when seemingly every effort is made to reduce the number of broken appointments, there remains an irreducible minimum, a residual, of unkept appointments with which providers have to cope. Some approaches include the following:

1. Providers with a small proportion of EPSDT eligibles in their practice may wish to disperse EPSDT appointments among other appointments, e.g., EPSDT appointments might be limited to one family per day, one family in the morning and one family in the afternoon, two families each Tuesday and Thursday afternoon, etc.

2. Providers with larger EPSDT caseloads may wish to concentrate their EPSDT appointments and to overschedule. If the broken appointment rate is quite stable, the number of screening appointments available may be multiplied by the broken appointment rate to determine the number by which to overschedule.

If there is substantial variation in the broken appointment rate from day to day, the provider must choose the level of overscheduling which minimizes idle time without exceeding absolute screening capacity when the daily broken appointment rate is at its lowest point.

A useful rule-of-thumb for beginning overscheduling is to overschedule by one-half of the number of expected broken

appointments. The ratio of overscheduling can then be adjusted, up or down, on the basis of experience. Usually the absolute capacity should not be exceeded by the past highest daily show rate multiplied by the number of appointments scheduled. (If more formal approaches are desired, see Shonick and Klein, 1975; Fetter and Thompson, 1966; Hoffman and Rockart, 1969.)

The latent reserve capacity of providers may be increased by training support personnel, such as receptionists and clerks, to assist with screening during periods of overload. With increased reserve capacity, providers can overschedule more appointments without exceeding their absolute capacity and, consequently, can operate at normal capacity more of the time.

Support personnel can easily be trained to perform height and weight measurements, collect specimens, take histories and perform vision and hearing testing.

Institutional providers can increase their reserve capacity by shifting staff from other clinics to EPSDT screening during occasional overloads resulting from overscheduling.

3. Providers can review the charts of EPSDT eligibles who are in the office for other reasons and can identify those children due for screening. These children may be screened during idle time created by broken appointments.

Parents should be interviewed to ensure that the children have not been screened by another provider since the last recorded screening visit. Parents may not know the meaning of the term "screening" and should be questioned about any recent visits for health care.

4. Providers may use idle time created by broken appointments to do administrative work. The staff may be instructed to reserve some administrative work which can be flexibly scheduled for times when EPSDT visits are scheduled. The time may be used for telephone consultation, record keeping and review, billing, ordering or stocking supplies, scheduling or rescheduling, etc.

5. Providers should compensate for cancelled EPSDT appointments by replacing them with other appointments for clients requesting immediate care. (Staff should educate clients during initial contacts about the importance of cancelling appointments and remind clients during subsequent visits to call if they cannot keep appointments.)

6. In a few instances, county welfare offices may wish to maintain standby lists of clients who are willing to be screened on short notice to fill broken appointments.

This approach has been used successfully in Kent County, Michigan. However, it is practical only under a narrowly restricted set of conditions.

The standby approach presupposes a group of highly motivated clients who are reluctant to wait a long time to be screened. This approach is unlikely to be practical unless there is a substantial waiting period for screening.

Using standby lists also requires excellent cooperation between screening providers and the county welfare office, and speedy escort service.

## VII. SUMMARY

This report summarizes the factors which contribute to broken appointments, makes recommendations on ways of reducing broken appointments and suggests some ways of minimizing the impact of residual broken appointments. The report is based on a review of the literature, Community Health Foundation's experience with other state EPSDT programs, and site visits to seven counties in Pennsylvania.

Many of the factors which contribute to the broken appointment problem are clearly beyond the direct control of state welfare agencies. These agencies can have little effect on family structures and the social integration of the larger society.

Cultural values and health beliefs are also slow to change. However, outreach workers and health workers can have an impact, if their efforts are consistent, coordinated and multi-dimensional.

A multi-dimensional approach is essential because broken appointments are determined by multiple factors. Many interacting variables contribute to determining the level of broken appointments. Changes on one dimension may have little impact unless accompanied by changes on other dimensions. For example, the extent to which relations between clients, health providers and outreach workers are personalized will limit the effectiveness of other recommended changes.

Some procedural matters are directly under the control of the Department of Public Welfare. For example, the procedure of reminding clients of their appointments is already state policy and needs only to be more rigorously enforced.

Some alternative ways of organizing screening are suggested which eliminate or minimize the no-show problem in screening. These policy options should be applied selectively with due consideration to the climate of opinion of local providers and local conditions.

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Attachment

***Report on EPSDT Outreach Programs in  
Bay, Ingham and Kent Counties***

**Department of Social Services**



WILLIAM G. MILLIKEN, Governor  
DEPARTMENT OF SOCIAL SERVICES

300 S. CAPITOL AVENUE, LANSING, MICHIGAN 48926

JOHN T. DEMPSEY, Director

SUBJECT: Report on EPSDT Outreach Programs in Bay, Ingham and Kent Counties

The attached report provides a description of three successful county EPSDT outreach efforts. It is hoped that the successful experience of these counties will provide insight which will be helpful to other counties. All local administrators and EPSDT personnel are urged to review the attached report and use its contents to reassess and revise, where appropriate, their own programs. We also wish to congratulate Bay, Ingham and Kent counties for implementing effective outreach efforts. Bay county has achieved outstanding recruiting success throughout the lifetime of the program. Ingham and Kent counties initially had difficulties with EPSDT, or at least did not reach high performance levels, but then made significant improvements in their programs which are now reflected in their record. The changes which they independently made are quite similar and would seem to suggest a great deal about what is needed for a successful EPSDT outreach program.

One shortcoming of focusing depth on these three programs is that we are consequently unable to assess many other counties which have positive features and results. However, we do expect that at least some other programs can be similarly reviewed in the future. At this point, we were especially interested in larger counties since it is in these areas where implementation has generally been most difficult.

Again, congratulations to Bay, Ingham and Kent counties. We hope their experience is of interest and assistance to others. I would also like to take this opportunity to thank all other counties and their personnel working in EPSDT for their continued efforts to operate a successful program. Relative to other states, Michigan continues to have an outstanding program and that is an achievement in which we can all take pride.

Sincerely,

John T. Dempsey

EPSDT IN BAY COUNTY  
WITH  
SUPPLEMENT ON INGHAM AND KENT COUNTIES

During the first two years of EPSDT, Spring 1973 through Spring 1975, Bay County screened somewhat more children than called for by contract. In other words, they averaged over 100% of optimum clinic capacity for the initial 24-month period. This is a performance unequaled by any other county and Bay has consistently placed first among other counties on this ranking. As a result, considerable interest has been generated in how Bay County has achieved and maintained such a high performance level.

Also of interest are the changes occurring in the Ingham and Kent County programs between the summer of 1974 and summer, 1975. During this time, both counties moved from averaging around 40-60% respectively of optimum capacity to an average of 80% and higher. In the interim, a number of changes were instituted which appear to have made the difference.

How all three counties operate EPSDT is the subject of the following report. Specifically, this report will attempt to describe and analyze the EPSDT outreach systems in Bay, Ingham and Kent Counties. Attention will be on county procedures, positive changes made and identification of those program elements which seem particularly responsible for success. Since larger counties generally have more difficulty in filling clinics, we were especially interested in the operation of these three counties. There are certainly other counties with good statistical records and features of their programs that are worthy of attention. It is quite possible some of these can be reviewed in the future.

The purpose of this report is to provide counties with several models against which to compare their programs and/or to furnish some new ideas which may be of assistance. Hopefully, the report will contribute to better understanding of program delivery and will ultimately lead to more effective outreach efforts.

The report is substantially the work of Ms. JoAnne Kanter who received full assistance and cooperation from county administration and staff. At the time of the study, Ms. Kanter was with the University of Michigan, School of Public Health. Bill Keller, MDSS, Basic Family Services Division, was also involved and can be reached for any general questions or comments at 373-7650, Lansing.

### Bay County - Program Structure

Bay County has one screening clinic located in Bay City. It is open three days per week to screen eighteen children per day.

Prior to June 1974, there were nine Basic Family Services and WIN workers (09) working part time on EPSDT (in total, 110 hours). These nine workers formed 3 teams with 3 people per team. Each team, led by a team captain, was responsible for 1 clinic day. This approach was statistically successful. Local administrators feel key ingredients in the success were the total number of hours input to the program (110) combined with administrative insistence and expectation that the county's goal be met. However, it was very difficult for the workers to cover EPSDT as well as their other program responsibilities. Consequently the switch was made June 1974 to a specialized unit doing only EPSDT. Three workers were selected to devote 110 hours of staff time to the program. This arrangement has continued. Two workers are public service aides; the third is at the 09 level. Each worker (team) is responsible for 1 clinic day. Responsibility and accountability is therefore high and clear cut. On the assigned clinic day, the worker is in the DSS office or at the clinic making sure appointments are kept, arranging emergency transportation, etc. The other 4 days find the worker in the community doing outreach.

### Competition and Cooperation Among Teams

In an effort to make EPSDT interesting for workers, Bay County has always attempted to develop and promote worker competition. At the end of each month, a statistical summary of each worker's appointment keeping performance is distributed to the 3 outreach workers, the first line supervisor, Supervisor for Social Services, Deputy Director, and Director of the County. It is also available for any interested office staff (refer to Appendix 1). In addition, an account of the month's screening results appears in the county's DSS newsletter. Even though competition does exist to produce the highest rate of filling the clinic, the teams do have a positive and cooperative relationship.

The 2 aides have had their children screened by the clinic. They are, therefore, well acquainted with all aspects of the screening and referral program and can thus more readily sell the program to clients.

### Intake

The county learns of eligible cases through AP referrals, child welfare staff, self-referrals, public schools, and the monthly printouts. In addition, whenever a family applies for ADC, they are invited to attend an orientation meeting. Depending upon the influx of new applicants, the meeting is held approximately every two weeks. Usually 10 to 20 new applicants come back to the DSS office to attend the scheduled orientation at which time all DSS programs are discussed. EPSDT is stressed and all interested families are scheduled for appointments right at this time.

In mid 1975, the county reviewed their entire ADC caseload and uncovered many families that had not been previously notified of EPSDT.

### Outreach

In notifying families of their eligibility for EPSDT, the outreach worker makes all attempts to visit the family at its home. Personal contact is greatly stressed in the outreach phase. If the parent is home, the worker explains the program and if interest is expressed, the children are given screening appointments. If the parent is not home, the worker leaves his card, asking the parent to contact him on a specific day. The worker does not note on the card the reason for his visit. This is purposely done so as to arouse curiosity in the family. When the parent does call, the worker explains EPSDT and follows through with appointment making, transportation, etc., if necessary.

Bay County attempts to reach all EPSDT eligible families. If a family does not want screening, this is of course accented. However, once a family commits itself to screening, every effort is made to make sure they show for their appointment.

On clinic day, the responsible aide or service worker will call the clinic every hour to learn which clients have shown for their appointments. If a client fails to show, the outreach worker will immediately go to the home and attempt to get the family to the clinic.

The county's outreach is "aggressive". For example, on one occasion an aide learned that a family could not keep its appointment because the mother was babysitting for her neighbor's children. Rather than let the appointment go unfilled, the aide helped the mother get all her children and the neighbor's children together, washed and dressed - then the aide, mother and 8 children all went in one car to the screening clinic. Although the neighbor's children were not screened, the client's family did get its EPSDT screening that day.

Another example of aggressive outreach occurred when an aide found that a mother had unexpectedly been taken to the hospital. The aide went to the hospital to help the mother with health history forms. She then proceeded to the client's home and brought the children in for screening.

The persistence illustrated in the above two examples reveal much of how the county is able to fill their clinics.

### Appointment Making

The Bay County Health Department is contracted to screen 2300 people annually, or 18 children on each of the three clinic days. Overscheduling is encouraged, thereby increasing the number of appointments to 22 a day.

DSS attempts to make appointments as far in advance as possible, however, this does not always occur. Usually an appointment is arranged from three to 7 days prior to the date of screening. Families are reminded of their appointment a few days prior by a reminder card sent in the mail. Those families whose appointments were arranged one or two days prior to the screening are not sent

a card nor are they reminded by a telephone call. The service aides found that in such cases their reminders were more of a nuisance than a help to the family.

Families are screened as a unit, however, the Department of Public Health does not encourage screening six or more children from one family at one time, especially when several Denver Developmental Tests must be given.

When making appointments, the service aides attempt to space those children requiring the Denver Developmental. This reduces the waiting time for other EPSDT clients and is easier on the clinic technicians.

Bay County, in the past, has set aside one day each month to screen the Mexican Americans in the area. Known as Migrant Monday, the clinic screens just Spanish speaking individuals on that day, thereby, making the day special for that group. This idea was developed after local program analysis revealed the Department was not doing well in attracting Spanish speaking families to screening.

#### Transportation and Child Care

For those families wishing EPSDT services, every effort is made to get the family into the clinic at its appointment time. Transportation arrangements are arranged when the appointment is made. The practice has been to inform the family of transportation without the family having to ask about it. In the past, EPSDT depended heavily on the use of volunteer drivers. The first line supervisor for EPSDT also supervised volunteer services in Bay County. Hence, coordinating available volunteer drivers with EPSDT needs was facilitated.

Aides have often used their own cars to bring the family to the clinic. This was especially done in situations where a family scheduled an appointment and failed to show. The aide would then go out to the family's home and provide them transportation.

#### Rescreenings

A card file has been developed which helps identify those individuals who should be rescreened.

Each card includes the following information:

- case name
- case number
- current address
- phone number
- children's names, identification numbers, birthdates
- appointments: kept/not kept; who went through

This information is obtained from past screening records, current screening lists, and case records.

### Department of Public Health

DPH screens children at 20 minute intervals. Those families arriving late for their appointments are not turned away. They may have to wait until the clinic is less crowded, but they usually do get screened. Those families arriving with incomplete health history forms also are not turned away. Rather, the clerk helps fill in the form.

Upon commencement of the screening, each child is followed through by the same technician, beginning with the least anxiety providing tests and working through to the blood tests.

### Summary of Bay County's EPSDT Project

The following is a list of what appears to be the key points for success in Bay County:

1. Wallace Nielson, Supervisor of Social Services and Margaret Taylor, first line supervisor, have given much support and encouragement to their EPSDT workers. The emphasis, expectations, and attention to EPSDT is exceedingly high among local administration and workers. For one example, during the first two months of the program, Bay County filled the clinic at about a 90% level. Staff was quickly and firmly told that this performance did not meet the agency's expectation. They were falling short and the goal they were to achieve remained at 100% or higher. In reviewing Bay County's program, one is continually impressed by the emphasis they have placed on EPSDT.
2. There has been a concerted attempt to identify problem areas and find solutions for these problems. For example:
  - A. When program review disclosed Spanish speaking youngsters were not optimally participating in EPSDT, a special day was set aside at the clinic for this group.
  - B. When it became apparent that the first and last clinic appointments of the day were less likely to be kept, the county, at one point, began driving families scheduled for these times regardless of whether they had transportation.
  - C. A determination was made that 110 hours of worker time was needed to administer the program. The county then assigned personnel so this amount of time could be inputed to the program.
3. Each worker is assigned a clinic day and competition exists among workers as to who can produce the best show results. Workers also strive to make the county's statistics tops in the state. Specific allocation of a clinic day makes responsibility and accountability clear out.

4. Outreach workers call the clinic every hour to see which appointments were not kept. The worker then calls the client, following through with emergency transportation, child care etc., making every attempt to get the family into the clinic.
5. Transportation has been made readily available through volunteers or outreach workers.

Other efforts which seem helpful are:

1. Group meetings are held for all new service cases. EPSDT is stressed at this meeting and interested families are scheduled for appointments at this time.
2. DSS overschedules 4 persons per day, when possible.
3. Clients are reminded of their appointments by a reminder card and/or phone call a few days prior to the appointments.

#### Ingham County

A brief look at Ingham County statistics reveals significant changes over the past year and a half.

<u>9/73</u> 45%	<u>10/73</u> 35%	<u>11/73</u> 39%	<u>12/73</u> 46%	<u>1/74</u> 50%	<u>2/74</u> 35%	<u>3/74</u> 36%	<u>4/74</u> 52%	<u>5/74</u> 39%	<u>6/74</u> 31%	<u>7/74</u> 43%	<u>8/74</u> 40%
<u>9/74</u> 58%	<u>10/74</u> 73%	<u>11/74</u> 71%	<u>12/74</u> 49%	<u>1/75*</u> 60%	<u>2/75*</u> 66%	<u>3/75</u> 76%	<u>4/75</u> 82%	<u>5/75</u> 71%	<u>6/75</u> 60%	<u>7/75</u> 79%	<u>8/75</u> 85%
<u>9/75</u> 73%	<u>10/75</u> 70%										

The above increase did not occur by chance. There were specific program modifications undertaken by the county to improve clinic utilization. Perhaps of prime importance was the restructuring of the outreach staff.

Prior to July 1974, EPSDT was carried out by one aide and the BFS and SAU service workers. These workers did EPSDT home calls, follow-up and transportation as well as other programs. However, beginning in July 1974, the first steps were taken toward creating a specialized unit to do only EPSDT. In that month two additional aides were hired, followed by the hiring of a third one in August. In September 1974, an EPSDT unit was organized. A new supervisor, Ms. Carol Cook, became involved and an OG was installed as program coordinator. Two additional aides began working in July 1975. Therefore, by summer, 1975, the EPSDT unit was composed of a supervisor, coordinator, and 6 aides. In short, the county moved from using generalist workers to forming a specialized EPSDT unit. Two aides are permanently responsible for office work, two aides do outreach, one aide provides transportation, and one aide is in the office doing office clerical work such as closing cases, etc.

\*Based on 720 appointments made available to DSS rather than 500 appointments

It was also early in the restructuring process that the county acquired two state cars to use for EPSDT transportation. A third was later added. Transportation had been a problem. Volunteers had been used as available but this recourse was not sufficient for the need.

Following is description of certain aspects of Ingham's program with particular attention to procedures which appear to be somewhat unique:

#### Intake

To identify new eligibles, the EPSDT unit makes considerable use of the DSS-5A. This is done in the following manner:

Ongoing AP and intake clerical staff strip the DSS-5's upon review and opening of cases. These 5's are then sent to the main services clearing file. From here the 5's are distributed to services units according to the following guidelines: All 5's on which there are active BFS or SAU cases are transferred to the EPSDT unit. All cases in which there have never been previous services are sent to BFS unit for initial services contact. If any of these are cases that have been open for a long time since intake services was done at the agency, they are transferred to the EPSDT unit. Once the 5's reach the EPSDT unit, they are checked with the card catalogue. If the case has been open in the EPSDT unit within the last year, the 5 is destroyed. If a case has not been open within the unit during this time period, a case is opened. This is done by clerical staff. The case is then sent to the appropriate outreach worker for a home call.

BFS receives intake services referrals and SAU receives new WIN referrals from intake. These workers make original home calls on the SAU and BFS cases. At that time they automatically explain the EPSDT program. If the new ADC recipients wish EPSDT, a referral is sent to the EPSDT unit. The EPSDT unit arranges for scheduling, transportation and follow-up.

The county has found the monthly printout to be of little help.

#### Outreach

Approximately all of the outreach in Ingham County is done through personal contact/home visits. The two aides doing outreach each make 20 home visits per day. If a parent expresses interest in EPSDT, appointments are arranged at this time and health history forms, with each child's name at the top, are given to the parent to fill in. Also, the parent is given a letter which verifies in writing the location and date of the appointment. Letters are available in English and Spanish.

In those situations where no one is home, the aide leaves a letter in the mail box explaining the reason for the visit and an EPSDT brochure.

Aggressive outreach is conducted. However, like Bay County, greater emphasis is placed on those families who commit screening themselves to appointments at the expense of attempting to persuade those families not interested in EPSDT.

### Appointment Making

Ingham County is contracted to screen 8000 people per year, or 36 persons daily. Overscheduling is encouraged, thereby increasing the number of appointments to 44 per day.

Occasionally DSS is able to schedule appointments for one week in advance, but generally speaking most appointments are made one or two days prior to the screening. In cases where several days lapse between the time the appointment was made and the actual screening, DSS or the clinic will call the client to remind him of his screening. If there is no phone, the client is not reminded.

An appointment book (spiral notebook) lists each screening day and who is to be screened at what time. Appointments are spaced 20 minutes apart. For those clients needing transportation, a notation is made next to their names. If a child misses his appointment, the aide will personally contact the parent and try to reschedule the child. If the parent is not home, a letter is sent.

### Transportation and Child Care

Ingham County has utilized volunteers as well as aides for providing transportation. Three state cars are available for this purpose. A transportation book lists each screening day and those clients needing transportation for that day (obtained from the appointment book). Besides listing the client's name, also noted are the address, time and destination.

DSS contends that the show rate is considerably higher if they provide the transportation rather than depending upon the client. The EPSDT unit will provide transportation not only for screenings and initial referral visits but for all visits determined needed by the screening assessment. This may include as many as three or four return visits to the dentist or doctor.

There is not a demand for child care services in Ingham County's EPSDT Project.

### Card File

Like Bay County, Ingham has developed a card file control of every case screened.

### Statistical Controls

Ingham County's EPSDT unit has also developed a reporting system compiling daily, weekly and monthly statistics. (Appendices 2 and 3). Completed by the EPSDT coordinator, one can quickly note statistics regarding the number of appointments made available, number scheduled, screened, transportation requests, car mileage, etc. This information is helpful for the first line supervisor who can then detect problems and decide where greater emphasis should be placed.

### Kent County

In the past 18 months, Kent County's capacity rate has improved considerably, reaching highs of 88% in April, 89% in May, and 87% in August of 1975. In fact, it is impressive to look at the steady statistical progress that has been made over the past year and a half.

$\frac{6/74}{47\%}$	$\frac{7/74}{50\%}$	$\frac{8/74}{60\%}$	$\frac{9/74}{62\%}$	$\frac{10/74}{63\%}$	$\frac{11/74}{68\%}$	$\frac{12/74}{63\%}$	$\frac{1/75}{66\%}$	$\frac{2/75}{72\%}$	$\frac{3/75}{67\%}$	$\frac{4/75}{88\%}$	$\frac{5/75}{89\%}$
$\frac{6/75}{75\%}$	$\frac{7/75}{76\%}$	$\frac{8/75}{87\%}$	$\frac{9/75}{80\%}$	$\frac{10/75}{83\%}$							

Like Ingham County, Kent's EPSDT project underwent several program modifications in August 1974. A specialized EPSDT unit was formed with Ms. Frances Snyder as coordinator. It is also the writer's impression that the second line supervisor, Mr. Andrew Zylstra, has given the program much cooperation and encouragement.

To move to a specialized unit resulted in a team of 6 aides and 1 clerk.

Following is an outline of the Kent operation:

#### Intake

Besides using the monthly printout, the EPSDT unit receives referrals on all ADC cases opened by Assistance Payments Intake. Ms. Snyder then assigns the referrals to the aides in their respective districts. A rolodex card file system is being compiled for each case as it comes in. The cards have information similar to that in Bay County.

#### Outreach

The aides do most of their initial outreach using the telephone and mail. Initially they send a letter to all eligible clients giving them information regarding health services and asking the client to contact them. Ninety percent of the clients reportedly call back. At this time, the aide explains EPSDT to the client and, if the client expresses interest, sends a brochure and schedules a screening appointment. If the client does not call, a second letter is sent, followed by a home visit.

#### Appointment Making

Each of the six aides is assigned a certain day for which he is responsible to schedule appointments. However, the aides work together and if a client wants to be screened on a day not assigned to the aide, she still schedules the client for the other day.

Appointments are made approximately one week in advance. Four screening are scheduled every 30 minutes. The aides are given 40 appointments a day to schedule, but are encouraged to overschedule to 44.

The client is reminded of his appointments 3 days prior by a reminder card. The aide will also call the afternoon before screening. If DSS is providing transportation, the aide will call the client the morning of the appointment as a final reminder.

If a client fails to show for screening, the aide will call within one week of the appointment to find out why the appointment was missed. At this time a second screening appointment is made, if desired.

### Transportation and Child Care

When informing the client about EPSDT, the aide offer transportation facilities before being asked about them. Kent County has three station wagons (state cars) that are driven by the aides. Volunteers were not depended upon for transportation for the initial screening.

Volunteer babysitters are available but there is seldom need for them in the EPSDT project.

### Rescreenings

Working with DPH, the EPSDT unit determines who is eligible for rescreenings via the monthly printout. A list of eligible children, their ID numbers, and birthdates are extracted from the monthly printout and sent to the Health Department. The Health Department will then note those cases eligible for rescreening and send a confirmed list back to DSS.

### Services Packet

Kent County has devised an EPSDT Services Packet for each eligible family it screens. The Services Packet is a comprehensive and up-to date record of the client's status in EPSDT. Forms included in the packet are Service Eligibility Determination (1928A), Client Service Referral (332-133), BFS Report (638) the referral services from the Health Department (MDPH 639) and the Medicaid Screening Summary (MDPH 637). This packet is quite useful during the Federal audits.

### Local Explanation of Improvement

Mr. Andrew L. Zylstra, Section Supervisor in Kent County, feels two factors are especially responsible for the improved statistics:

First, he believes specialization through the use of one service worker coordinating the activities of seven service aides has greatly increased the efficiency and effectiveness of service delivery. Where EPSDT was once just one of many activities of a service worker, the program is now the single major responsibility of the service aide. Whereas before, the service worker was responsible for "selling" the client on EPSDT services and then assuring follow through by the client, now the service worker can still "sell" the service but need not take responsibility for the details of client follow through, including transportation problems and scheduling, etc. These details are efficiently handled by the service aides who have become known for their persistence in resolving problems in this area.

The service aides are also highly goal oriented. Mr. Zylstra sees Ms. Snyder, the coordinator, as extremely effective in establishing a unit pride in obtaining the goal of screening 40 recipients each day. A yearly goal of screening 80% of the optimum capacity figure was set for the unit. Even though staffing limitations have restricted accomplishing the ideal of 100% optimum capacity the unit has exceed the 80% figure several months during the last year. o

The second factor which Mr. Zylstra believes has had a major effect on the increased success of the program is the availability of the three State cars. "Our ability to provide reliable transportation for our clients lacking transportation cannot be underestimated." This is seen as especially true when the clinic is located away from public transportation routes. Mr. Zylstra also believes the DSS willingness to provide transportation when needed is seen by client as a real agency commitment to a program we advise them is of great value.

#### Overall Summary

- The EPSDT units in Bay, Ingham and Kent counties have all received encouragement, attention, and cooperation from their administrations. Periodic mention of the work each counties' unit is doing has been noted in monthly newsletters and/or in internal memos, etc.
- All three counties have specialized units developed just for EPSDT. Aides and service workers devote all their efforts toward this project. Specialization definitely appears to contribute to pinpointing responsibility and increasing emphasis and attention to the program. Generalist workers must always contend with crises in other programs and shifting program priorities. Simply in terms of most effectively carrying out EPSDT, it is the experience of these counties, and others, that a specialized unit or worker has many advantages.
- Transportation has been minimized as a problem since each of the counties has made transportation provisions for their clients. Bay depended heavily on its volunteers whereas Kent used state cars (3) driven by the aides. Ingham has had both aides and volunteers driving state cars (3).
- The three counties are all developing card file systems for future rescreenings.
- Reminder cards and/or phone calls are used to remind the client of his upcoming appointment. Usually cards are received or phone calls made the day prior to the screening, although in some cases, a client is reminded of the appointment the day it is to be screened (Kent).
- Overscheduling is done in all 3 counties.
- Ingham County has developed a statistical control system listing daily, weekly and monthly EPSDT related statistics. This informs the first line supervisor of what exactly is happening and where more program emphasis should be.

BayCounty has an internal competition among its workers to see who brings in the best results for the month. This friendly cooperation appears to help develop worker interest in the program.

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- It might be helpful for other counties, particularly large ones, to compare their staffing ratios with those of these counties. There are at least two ways this might be done. One approach would be to compare the number of workers against the clients to be screened per contract. In the counties studied, this would look as follows:

County	Number Aides	Number Coordinators	Total Workers	No. to Screen Per Contract	Ratio Workers - Clients
Bay	2	1	3	2,300	1 - 767
Ingham	6	1	7	8,000	1 - 1,143
Kent	6	1	7	10,000	1 - 1,429

That is, in Bay, there is one full time worker for each 767 clients to be screened per year etc. A second way to look at essentially the same figures is to remember that Bay has one worker for each weekly clinic. Ingham and Kent would have 7/10 a worker for each weekly clinic (7 workers and 10 clinics per week).

- Dedication, interest, persistence, prioritizing etc. are all admittedly intangible and difficult qualities to measure. However, it is the recurring impression that these qualities are present - at various administrative and worker levels - in the above counties.
- Kent County has devised a Services Packet for each EPSDT family. It includes Service Eligibility Determination (1928A), Client Service Referral (332-133), old BFS Report 638, the Referral from the Health Department (MDPH 639) and the Medicaid Screening Summary (MDPH 637). This is quite useful during federal audits.

The above counties have demonstrated that high performance levels in screening can be achieved. We have attempted to isolate the factors making for their success so other counties can profit from this experience. We would hope that the many other counties also doing well in the program can find some useful, new ideas in the above. We would also hope that counties experiencing EPSDT difficulties will compare their operations with the above, find some new directions, and alter their programs where appropriate.

If there are questions regarding the programs in these counties, please feel free to contact the following people:

Ms. Margaret Taylor, Services Supervisor, Bay County Department of Social Services, 912 Adams Street, Bay City, MI 48706 (517) - 894-4161.

Ms. Carol Cook, Services Supervisor, Ingham County Department of Social Services, 930 W. Holmes, Lansing, MI - (517) 373-0895.

Mr. Andrew L. Zylstra, Family Service Section Supervisor, Community Social Service Division, Kent County Department of Social Services, 415 Franklin, Southeast, Grand Rapids, MI 49507 - (616) 247-6261.

E.P.S.D.T. January 1975

## Bay County

Monday Team

Tuesday Team

Thursday Team

REID

BENSON

QUADE

Day Appts. Kept

Day Appt. Kept

Day Appt. Kept

6 - 21

7 - 20

2 - 16

9 - 18

20 - 18

14 - 22

16 - 15

27 - 19

21 - 22

23 - 21

28 - 19

30 - 20

Totals

58

83

90

SLOTS AVAILABLE

54

72

90

GOAL ACHIEVEMENT

58/54 = 107%

83/72 = 116%

90/90 = 100%

APPOINTMENTS NOT KEPT

6 - 1

7 - 1

2 - 4

9 - 4

20 - 2

14 - 0

16 - 7

27 - 3

21 - 0

23 - 1

28 - 0

30 - 1

Totals

6

1

17

REFERRED ON FOR DIAGNOSIS &amp; TREATMENT

6 - 29

7 - 9

2 - 6

9 - 16

20 - 20

14 - 19

16 - 6

27 - 8

21 - 10

23 - 8

28 - 23

30 - 7

Totals

57

61

43

Referred on for diagnosis and treatment: 161 = 70%

Overall goal achievement for unit: 100% + 15% = 107%

215 slots available

0

231 slots filled

STATE OF MICHIGAN  
DEPARTMENT OF SOCIAL SERVICES

APPENDIX 2

MEMORANDUM

WEEKLY STATISTICAL REPORT

Date

To: Roger Shutes

From: Carol Cook, E.P.S.D.T. Supervisor

By: Patty Caszatt, E.P.S.D.T. Co-ordinator

Subject: Project Health and Emergency Food Weekly Report.

Clinic appointments available:

Appointments scheduled:

Screened:

Called and cancelled before appointment:

Called and cancelled before appointment and asked to be rescheduled:

(The above figures are numbers of individuals)

Transportation requests:

Transported to clinic:

Requested transportation but refused transportation when worker arrived,  
or were not at home:

(The above figures are numbers of families)

Total state car mileage:

Number of hours state cars were in use:

Mon.

Tues.

Wed.

Thurs.

Fri.

Car 1

Car 2

Car 3

Emergency food requests:

Emergency food requests filled:

[illegible]

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